

**DRVD
CONFIDENTIAL REPORT**

AN INVESTIGATION INTO THE DEATH OF JW

Twenty year-old, male resident of Western State Hospital, dies after being struck by an automobile while attempting to cross a busy highway in Staunton, Virginia.

**DRVD CASE# 96-0187 M
Department For Rights of Virginians With Disabilities
Beth Chadwell, Advocate
February 1997**

I. INTRODUCTION:

This report is a summary of the findings from the Department For Rights of Virginians With Disabilities' (DRVD's) investigation into the death of JW, a 20 year-old, white male, who was a resident at Western State Hospital (WSH) in Staunton, Virginia. JW was struck and killed by an automobile near WSH, while attempting to cross a busy highway, at approximately 6:03 PM on 1/26/96. Sight distance at the time of JW's death was reported as limited, by WSH Security personnel, due to it being dark and raining outside when the incident occurred. JW was wearing a dark green and purple coat and a pair of dark green pants.

This investigation was undertaken as part of DRVD's responsibility pursuant to USC 42 10805 et.seq., to investigate incidents of abuse and neglect when reported or if there is probable cause to believe they have occurred.

DRVD's investigation has included the following:

1. Reviewing JW's medical records at WSH.
2. Interviewing WSH Risk Manager regarding JW.
3. Reviewing Staunton Police Department incident report regarding JW.
4. Reviewing WSH Security Report regarding JW.

II. BACKGROUND:

JW was a 20 year-old, hard of hearing, white male, from Fairfax, Virginia, who was transferred to WSH on 1/29/95. Prior to his transfer to WSH, he was hospitalized at Dominion Hospital, where he was admitted on 1/19/95, after

pulling a knife on his parents when they refused to let him drive their car. JW had a long history of inability to control his impulses and anger, which resulted in several hospitalizations. His parents reside in Fairfax, Virginia and maintained a close relationship with JW up to his death on 1/26/96. JW took frequent passes to his parent's home in Fairfax and was capable of riding the Amtrak train from Staunton to Fairfax, unescorted by hospital staff.

According to records from WSH, JW's psychiatric diagnoses were as follows:

Axis I: Intermittent Explosive Disorder
Axis II: Borderline Intellectual Functioning
Axis III: Hard of Hearing

His medication record as of January 1996 reflected JW was being treated with the following medications by WSH at the time of his death:

Lithium 300mg q8am q4pm
600mg qhs
Mellaril 10 mg tid

Records indicate at the time of JW's admission to WSH on 1/26/95, he was being treated with carbamazepine 200 mg. QID, which was originally prescribed for him by the Woodburn Mental Health Center in Fairfax. This dosage of carbamazepine caused JW to experienced an adverse reaction and as a result the medication was discontinued by his WSH physician on 1/31/95.

III. CIRCUMSTANCES SURROUNDING THE DEATH OF JW

A. Care Provided to JW at WSH

JW was transferred to WSH from Dominion Hospital in Fairfax, Virginia on 1/26/95 and was assigned to Ward D7/8, Mental Health Center for the Deaf, due to his psychiatric and hearing disabilities. Shortly after his transfer to WSH, JW developed thrombocytopenia, as an adverse reaction to the carbamazepine, which had been previously prescribed for him by the Woodburn Mental Health Center in Fairfax. He was sent to the University of Virginia Hospital and given multiple transfusions in order to increase his blood counts. He was stabilized there and subsequently returned to WSH. The carbamazepine was discontinued 1/31/95 by his WSH physician.

His medical record indicated, other than poor vision and impaired hearing, he was in good physical condition at the time of his death. While at WSH,

he was tried on Paxil, Ativan, Buspar, and Lithium, but at the time of his death he was on the following medications:

Lithium 300mg. q8am q4pm 600mg. qhs
Mellaril 10mg. tid

JW's progression in the ward program and with his treatment plan was slow and at times he would continue to be very intrusive to others as well as resistive to direction and structure. He had great difficulty in forming social relationships and accepting responsibility for his actions. He attended the WSH school program regularly on the grounds of the hospital and went home and off grounds for unescorted passes.

JW was ready for discharge from WSH at the time of his death. He had been scheduled to begin a two week pass to discharge to Merriman House, a group home for deaf and mentally impaired adults in Hampton, Va. on 1/31/96.

B. January 26, 1996 Sequence of Events

JW had been on a temporary pass at his parents home in Fairfax, Virginia from 1/24/96 - 1/26/96. He was picked up from the Staunton train station on 1/26/96 by Ward D7/8 staff, and returned to WSH, at approximately 3:00 p.m. Upon his return to Ward D 7/8, JW requested and received, per his treatment plan, an unescorted, off grounds pass to the nearby Wal-Mart store, located on U.S. Route 250, near WSH. JW's current treatment plan provided for two off grounds passes a week, and these were pre-approved by his treatment team and physician, Dr. Barbara Haskins. The off grounds pass was given to JW at approximately 4:30 PM. He then left Western State Hospital on foot, enroute to the Wal-Mart store. The WSH security report documented JW was stopped by security personnel near the front entrance of WSH to check his pass for off grounds privileges, since he was walking in the direction of leaving the hospital grounds. His pass clearly stated off grounds privileges were approved for him. The approximate time WSH security personnel checked JW's pass was not documented.

Upon his apparent return on foot, from the Wal-Mart store to WSH, JW was walking eastbound on the far right median of eastbound Route 250, reportedly carrying several articles he had purchased at Wal-Mart under his arm. JW then reportedly ran across Route 250, apparently to cross the road, when a Dodge van, struck and killed him. The driver of the van, stated he did not see JW until he was in front of his van. The driver stated he tried to

get the van stopped, but it was too late. The driver stated JW came out of nowhere.

Ward D7/8 staff were notified by the WSH operator, at approximately 7:00 PM, that JW had been accidentally struck by an automobile on Route 250 while he was attempting to cross the road. JW was taken to Augusta Medical Center in Fishersville, Virginia where he was pronounced dead on arrival. The death was determined to be accidental by the Staunton Police Department. The Staunton Rescue Squad and the Staunton Fire Department were on the scene for medical assistance. No autopsy was performed. The time of death was determined to be approximately 6:03 PM on 1/26/96.

C. Investigations

The Staunton Police Department was at the scene and investigated the incident, and ruled the death as accidental in their incident report. The Virginia State Police did not investigate. There were no charges brought.

IV. FINDINGS AND CONCLUSIONS:

This investigation discovered no evidence abuse or neglect were involved in either JW's care and treatment at WSH or in his death on January 26, 1996. JW had been deemed capable of handling unescorted, off grounds passes by his treatment team and physician. WSH did operate a shuttle van during this time period, which transported and returned WSH residents to the Mall, Wal-Mart, etc. It is unknown as to why JW did not utilize the shuttle van to and from Wal-Mart on this date. No recommendations were made to WSH due to the accidental nature of JW's death and lack of evidence substantiating abuse or neglect on behalf of Western State Hospital.

V. RECOMMENDATIONS:

Due to a lack of sufficient evidence substantiating either abuse or neglect it is recommended this investigatory case be closed.